MEDPAC Medicare Payment Advisory Commission

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June 25, 2018

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue SW
Washington, DC 20201

RE: File Code CMS-1688-P

Dear Ms. Verma:

The Medicare Payment Advisory Commission (MedPAC) appreciates the opportunity to submit comments on the Centers for Medicare & Medicaid Services (CMS) proposed rule entitled, "Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2019; Proposed Rule," *Federal Register* 83, no. 89, 20972–21015 (May 8, 2018). We appreciate your staff's continuous efforts to administer and improve the Medicare payment system for inpatient rehabilitation facilities (IRFs), particularly given the competing demands on the agency.

This rule proposes a payment update and other revisions to Medicare payment policies for IRFs in fiscal year (FY) 2019 and proposes changes to the IRF Patient Assessment Instrument (IRF–PAI) and to certain IRF coverage requirements. The rule also proposes revisions and updates to the IRF Quality Reporting Program.

Proposed FY 2019 update to the Medicare payment rate for IRFs

CMS proposes a 1.35 percent increase to the IRF payment rate. CMS obtained this result by following the statutory formula of starting with the applicable market basket increase (estimated to be 2.9 percent) and subtracting a productivity estimate of 0.8 percentage points and an additional deduction of 0.75 percentage points; both reductions are required by the Patient Protection and Affordable Care Act (PPACA) of 2010. CMS also proposes an increase to the high-cost outlier threshold amount to maintain estimated outlier payments at 3 percent of total estimated aggregate IRF payments for FY 2019.

Comment

We understand that CMS is required to implement this statutory update. However, we note that after reviewing many factors—including indicators of beneficiary access to rehabilitative services, the supply of providers, and aggregate IRF Medicare margins, which have been above 10 percent since 2011—the Commission determined that Medicare's current payment rates for IRFs appear to be more than adequate and therefore recommended that the Congress reduce the IRF payment rate by 5 percent for FY 2019. We appreciate that CMS cited our recommendation, even while noting that the Secretary does not have the authority to deviate from statutorily mandated updates.

In conjunction with our March 2018 recommendation to reduce the IRF payment rate for FY 2019 by 5 percent, we reiterated our March 2016 recommendation that the IRF PPS outlier pool be expanded to redistribute payments within the IRF PPS and reduce the impact of potential misalignments between IRF payments and costs. This action is within the Secretary's authority. The recommendation was in response to Commission research suggesting that the IRF case-mix groups (CMGs) may not be adequately capturing differences in patient acuity and costs across cases and providers. We found that the mix of case types in IRFs is correlated with profitability. More costly cases, such as strokes, are disproportionately admitted by IRFs with lower margins, which could indicate that high-cost cases are less profitable than other cases. Expanding the outlier pool from the current level of 3 percent to 5 percent of aggregate IRF payments would ameliorate the financial burden for IRFs that have a relatively high share of costly cases. We recognize that, by increasing payments for the costliest cases, Medicare may increase payments for providers who are less efficient as well as for providers who care for patients whose acuity is not well captured by the case-mix system. Nevertheless, because of our concerns about the accuracy of Medicare's payments for resource-intensive cases, the Commission continues to believe that an expanded outlier pool is warranted in the near term. Over the longer term, until a unified PAC PPS is implemented, CMS must ensure the accuracy of Medicare's payments by determining that IRFs' assessment and scoring consistently reflects patients' level of disability.

Ultimately, the Commission has recommended that Medicare move away from setting-based payment to a unified PAC PPS with accurate and equitable payments for services provided in the four post-acute care settings (IRFs, skilled nursing facilities, home health agencies, and long-term care facilities). Such a system would use readily available data to pay for a PAC stay based on the patient's characteristics, not the site of service. A unified PAC PPS would improve the equity of payments by redistributing them across case types, increasing payments for medically complex patients and lowering payments for patients with less complex medical conditions. To accelerate the movement toward more equitable payments and to give providers time to adjust their practices and costs to the improved incentives of a unified PAC PPS, the Commission recommended in March 2018 that the Congress direct the Secretary to begin to redistribute payments within the IRF PPS by blending the current IRF relative weights with unified PAC PPS relative weights. (The Commission recommended such action for the other PAC settings as well.) A blend of the relative weights would not affect the aggregate level of payments to IRFs but would shift payments across different types of IRFs.

Proposed removal of the FIM™ instrument and associated function modifiers from the IRF–PAI beginning with FY 2020 and proposed refinements to the case-mix classification system beginning with FY 2020

Under current law, the Secretary can require IRFs to submit such data as he deems necessary to establish and administer the IRF PPS. Under the IRF PPS, for purposes of payment, patients are assigned to rehabilitation impairment categories (RICs) based on the principal diagnosis or primary reason for inpatient rehabilitation. Within each RIC, patients are sorted into case-mix groups (CMGs) based on the level of motor and cognitive function at admission and then further categorized into one of four tiers based on the presence of specific comorbidities that have been found to increase the cost of care. Each CMG and tier has a designated weight that reflects the average costliness of cases in the group compared with that of the average Medicare IRF case. The current IRF PPS case-mix classification system has 21 RICs (plus two categories for patients who have very short stays or who die while in the IRF) and 92 CMGs.

To determine the appropriate CMG, IRFs assess and score each patient's motor and cognitive function using the IRF Patient Assessment Instrument (IRF–PAI). The IRF–PAI is based on a modified version of the Uniform Data System for Medical Rehabilitation patient assessment instrument, commonly referred to as the Functional Independence Measure, or FIM™. The IRF–PAI's 18 FIM data elements and associated modifiers, along with the FIM measurement scale, are used to measure a patient's level of disability and the burden of care for a patient's caregivers. (All else equal, greater level of disability generally results in higher payment.)

The IRF–PAI also includes items that are standardized across PAC settings and are used to collect information on a patient's motor and cognitive function for the IRF Quality Reporting Program (QRP). As shown in Table 1, the QRP items are very similar to the FIM elements and associated modifiers. Because the QRP elements overlap with the FIM data elements, CMS believes that the collection of FIM elements and associated modifiers is no longer necessary and places undue burden on providers. Accordingly, CMS proposes to remove the FIM elements and associated modifiers from the IRF–PAI for all IRF discharges beginning on or after October 1, 2019, and to replace those elements with corresponding QRP items.

Because the QRP items are defined differently from the FIM elements and use a different scale of measurement, CMS's proposal would require some revisions to the CMG classification system. However, the similarity and overlap in the FIM and QRP items mean that CMS can replace FIM elements with QRP items without materially changing the case-mix classification system. CMS contracted with RTI International to determine how the QRP items could be used in place of the FIM elements in the case-mix classification system and what the impact on the payment system and providers would be. RTI International replicated the approach used to develop the current IRF classification system, substituting the QRP data elements for the FIM elements. All other aspects of the classification system are unchanged, including the RIC structure, the assignment of comorbidity tiers, and the methodology for calculating the payment weights. The CMG classification system would continue to have 21 RICs (plus two for patients who have very short stays or who die in the IRF). However, the revisions proposed by CMS would result in some

consolidation of CMGs, so that instead of 92 CMGs there would be 88. At the RIC level, the changes to the payment weights would be relatively small.

Table 1. Selected FIM™ elements and QRP counterparts on the IRF–PAI

	FIM	QRP
Self-care: Eating	*FIM item A*—The use of suitable utensils to bring food to the mouth, chewing and swallowing, once the meal is presented in the customary manner on a table or tray.	*GG130-A*—The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is placed before the patient.
Self-care: Bathing	*FIM item C*—Washing, rinsing, and drying the body from the neck down (excluding the back) in either a tub, shower, or sponge/bed bath.	*GG130-E*—The ability to bathe self in shower or tub, including washing, rinsing, and drying self.
Self-care: Dressing upper body	*FIM item D*—Dressing and undressing above the waist, as well as applying and removing a prosthesis or orthosis when applicable.	*GG130-F*—The ability to put on and remove shirt or pajama top; includes buttoning, if applicable.
Self-care: Toileting	*FIM item F*—Maintaining perineal hygiene and adjusting clothing before and after using a toilet, commode, bedpan, or urinal.	*GG130-C*—The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan, or urinal.
Transfers: Bed, chair, wheelchair	*FIM item I*—All aspects of transferring from bed to a chair, or wheelchair, or coming to a standing position, if walking is the typical mode of locomotion.	*GG170-D*—The ability to come to a standing position from sitting in a chair, or on the side of the bed. *GG170-E*—The ability to safely transfer to and from a bed to a chair (or wheelchair).
Transfers: Toilet	*FIM item J*—Includes safely getting on and off a standard toilet.	*GG170-F*—The ability to safely get on and off a toilet or commode.
Locomotion: Walk	*FIM item L*—Ability to/level of assistance needed to walk 150 feet.	*GG170-K*—Once standing, the ability to walk at least 150 feet in a corridor or similar space.

Note: FIM™ (Functional Independence Measure™); QRP (Quality Reporting Program); IRF–PAI (Inpatient Rehabilitation Facility–Patient Assessment Instrument.

Source: Centers for Medicare & Medicaid Services, Inpatient Rehabilitation Facility–Patient Assessment Instrument, Version 1.5.

CMS proposes to implement these revisions in a budget-neutral manner; however, RTI International's analyses suggest that there would be some redistributive effect of payments across providers, resulting in increased aggregate payments for hospital-based and nonprofit IRFs.

Comment

The Commission supports this proposal. Because the FIM items and modifiers are now redundant (due to the required collection of additional assessment information that is standardized across PAC settings), removing them from the IRF–PAI would relieve providers of having to report this information twice, using different definitions and measurement scales, which providers have indicated is a substantial burden. In addition, section 1899(b)(3) of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 requires the Secretary to replace existing setting-specific patient assessment data that duplicate or overlap with required PAC-standardized data "as soon as practicable." The overlap of the FIM and QRP items means that CMS can remove the FIM elements without making material changes to the IRF case-mix classification system. Substituting the QRP items for the FIM elements would result in no changes to the rehabilitation impairment categories used to describe IRF patients and would result in few changes to the CMGs. At the same time, moving toward an IRF classification system that uses data elements that are standardized across all PAC settings to adjust payments is a necessary step toward a unified PAC PPS. The Commission cautions CMS that the QRP items used in the CMG classification system should indeed be standardized—with definitions and specifications such as inclusions and exclusions—that are not just similar to but uniform with those in other PAC settings.

We note that CMS's analyses indicate that the minor revisions to the CMGs would result in some redistribution of payments across IRFs, at least in the short term. This suggests that assessments of patients' motor and cognitive function are not completely consistent across the two sets of data elements; that is, a patient's FIM function scores are not entirely necessarily predictive of the patient's QRP function scores.

It is interesting to consider why this might be so. Functional status data are generally obtained by observation of the patient and are somewhat subjective. Currently, the FIM scores are used to determine payment to IRFs, while the QRP scores have no effect on payment. Because payment is materially affected by patients' FIM scores at admission—with higher payments associated with lower functional status—providers have a financial incentive when scoring the FIM elements to minimize patients' assessed levels of function at admission. No such incentive exists currently for QRP scoring. However, that situation will change if CMS begins to use QRP scores to determine payment.

The integrity of Medicare's payment system for IRFs (and, indeed, for all prospective payment systems) is contingent on inter-rater reliability; that is, regardless of how the CMGs are defined and constructed, the payment system assumes that similar patients will be assigned to similar CMGs for purposes of payment. Otherwise, payments will not be properly aligned with resource costs. Some IRFs could receive payments that are too low relative to the costs incurred in treating patients, while other IRFs could receive payments that are too high. The Commission previously

has voiced concern about the inter-rater reliability of the current FIM elements in the IRF–PAI. As reported in our March 2016 report to the Congress, the Commission has found that, compared with low-margin IRFs, IRFs with high Medicare margins have patients who were, on average, less severely ill in the acute care hospital prior to IRF admission. Yet those patients were scored by high-margin IRFs as more functionally disabled, on average, than low-margin IRF patients. This finding suggests that assessment and scoring practices contribute to greater profitability in some IRFs, especially given the comparatively low level of costs and cost growth observed in high-margin facilities. Some in the industry have postulated that there are differences across IRFs in staff training and resources devoted to ensuring accurate patient assessment, resulting in less reliable measures of patients' motor and cognitive function in some IRFs. Others in the industry assert that some IRFs are aggressively assessing their patients so as to maximize payment. Regardless of the reason, we continue to urge CMS to ensure the accuracy of Medicare's payments and protect program integrity by confirming that IRFs' assessment and scoring consistently reflect patients' level of disability.

We note, however, that as long as payment relies on relatively subjective data such as patient functional status, these problems will likely persist. We anticipate that some providers will quickly respond to any IRF–PAI and CMG revisions by devoting resources to improving the coding of the QRP functional measures, altering their QRP scoring practices, or both.

Proposed revisions to certain IRF coverage requirements beginning with FY 2019

In the FY 2018 IRF proposed rule, CMS included a request for information (RFI) from stakeholders about ways in which the agency could reduce burden for hospitals and physicians, improve quality of care, and decrease costs. In response to the RFI, several commenters suggested that CMS decrease the number of required weekly face-to-face visits that the rehabilitation physician must complete. CMS also received comments suggesting that the agency allow the post-admission physician evaluation to count as one of the required face-to-face visits completed by the rehabilitation physician. Commenters suggested that the decrease in visits would not only assist with reducing the documentation burden on rehabilitation physicians, but would also afford the physician more time to focus on higher acuity, more complex patients, resulting in improved outcomes and lower readmission rates. In response, CMS proposes allowing the post-admission physician evaluation to count as one of the face-to-face physician visits required in the first week of the stay for all discharges beginning on or after October 1, 2018, and also proposes to change the requirement that a rehabilitation physician be physically present during the required weekly interdisciplinary team meetings. CMS believes it is appropriate, given advancements in technology, to allow rehabilitation physicians to lead the meeting remotely via another mode of communication, such as video or telephone conferencing.

CMS also seeks comment on whether a limited number of the required face-to-face visits can be appropriately provided remotely via video or telephone conferencing and whether non-physician practitioners should be able to fulfill some of the physician requirements to ease the documentation burden on rehabilitation physicians.

Comment

Medicare's conditions of coverage and payment serve in part to distinguish levels of care and levels of payment. Currently, each IRF is required to have a medical director of rehabilitation with training or experience in rehabilitation who providers services in the facility on a full-time basis (or at least 20 hours per week for hospital-based IRF units). In addition, for Medicare to make higher IRF payments for beneficiaries needing post-acute care, there must be a reasonable expectation that the beneficiary needs supervision by a rehabilitation physician, as reflected in three face-to-face visits each week. IRF patients also must be evaluated by a rehabilitation physician at admission. Beneficiaries whose conditions do not require close oversight by a physician can be cared for appropriately in other, less-intensive settings at a lower cost to the Medicare program.

The Commission has long noted the limited evidence on which PAC setting is best for a particular patient and what mix of services would achieve the best outcomes. The availability and use of PAC services varies widely by market, demonstrating the considerable overlap of clinical capabilities of some PAC providers. Reflecting this ambiguity and variation in service use, Medicare spending on PAC varies geographically more than any other service. Decisions about where to place patients often reflect several factors—the availability within a given market, the proximity to a beneficiary's home, patient and family preferences, and financial relationships between the referring hospital and the PAC provider—but not necessarily where the patient would receive the best care at the most reasonable cost to the program.

Providers' interest in loosening IRF conditions of coverage and payment suggests that such high levels of care may not be required by all beneficiaries who are cared for in an IRF, or that the level of resources needed to provide IRF-level care has fallen, or both. Eroding conditions of coverage and payment that have been established in part to ensure that Medicare's higher payments are warranted calls into question the level of those payments and provides further evidence that they may be too high. It also underscores the need for Medicare to move away from setting-based payments for PAC and towards a unified payment system that pays for PAC based on the characteristics of the patient and not on the setting in which the care is provided.

Proposed revisions and updates to the IRF Quality Reporting Program

PPACA required the Secretary to establish the IRF QRP. The IRF QRP is intended to allow comparisons of patient outcomes across providers. Beginning in FY 2014, the Secretary is required to reduce any annual update to the standard federal rate by 2 percentage points for any IRF that does not comply with the requirements established by the Secretary. The IRF QRP currently includes 18 measures. Data for seven measures are currently displayed on the IRF Compare website.

Meaningful Measures Initiative

In October 2017, CMS launched the Meaningful Measures Initiative aimed at improving patient outcomes and reducing burden by using a parsimonious set of the most meaningful measures for

patients, clinicians, and providers in quality programs. As a part of the initiative, CMS identified 19 high-priority areas for quality measurement, with a focus on improving patient outcomes (e.g., admissions and readmissions to hospitals, patient's experience of care, transfer of health information, preventive care). CMS also proposed 8 factors to determine if measures in these high priority areas are not meaningful (e.g., measure performance is high, costs associated with the measure outweigh the benefits). Overall, the Meaningful Measures Initiative represents a new approach to quality measurement in federal programs to foster operational efficiencies and reduce costs, including the collection and reporting burden, while producing quality measurement that is more focused on meaningful outcomes.

Comment

The Commission has recently formalized a set of principles for measuring quality in the Medicare program. Overall, quality measurement should be patient-oriented, encourage coordination, and promote delivery system change. The Commission asserts that Medicare quality incentive programs should use a small set of outcomes, patient experience, and value measures to assess the quality of care across different populations, such as beneficiaries enrolled in Medicare Advantage (MA) plans, accountable care organizations (ACOs), and fee-for-service (FFS) in defined market areas, as well as those cared for by specific groups of providers or clinicians. The goals of CMS's Meaningful Measures Initiative—to improve patient outcomes and reduce burden—align with the Commission's principles. As CMS continues to revise Medicare quality programs with a focus on meaningful measures, we encourage CMS to use a uniform set of population-based outcome measures across settings and populations.

Removal of two quality measures

CMS applied its meaningful measures factors to the IRF QRP. The agency found that the number of IRFs with expected methicillin-resistant *Staphylococcus aureus* (MRSA) infections during a given reporting period is extraordinarily low—too low to use for purposes of generating a reliable standardized infection ratio. In addition, the agency found that IRF performance on the measure of percent of patients assessed and appropriately given the seasonal influenza vaccine is so high and unvarying that meaningful distinctions in performance cannot be made. Based on this evaluation, CMS proposes to remove both of these measures beginning in FY 2020.

Comment

The Commission supports the removal of the two quality measures that are either topped-out (e.g., performance across IRFs is high), or for which the costs of measuring outweighs the benefits. As CMS continues to revise Medicare quality programs with a focus on meaningful measures, we encourage CMS to use a uniform set of population-based outcome measures across settings and populations.

Public display of quality measure data

CMS proposes to begin in CY 2020 public reporting on the IRF Compare website of four, facility-level assessment measures: (1) change in self-care; (2) change in mobility score; (3) discharge self-care score; (4) and discharge mobility score.

Comment

The Commission believes that public reporting of quality results can drive quality improvement by fostering competition across providers and allowing providers to better identify opportunities for improvement. Public reporting of quality results also allows beneficiaries to better compare and select providers. However, the Commission has concerns about Medicare's use of facility-reported assessment measures because providers may differ on their scoring of the assessments. As noted above, functional status data are generally obtained by observing the patient and are somewhat subjective. Because they are used to determine payment, providers have strong incentives to manipulate these data. In addition, when payment or public reporting are tied to assessment results, facilities have incentives to record a patient's function lower than it is at admission and to record it higher than it is at discharge. For this reason, the Commission advised readers of our March 2018 report to the Congress that MedPAC's own measures of functional improvement, reported at the provider-group level, should be interpreted with caution. As noted above, the Commission encourages CMS to monitor the accuracy of the assessment data, both at admission and at discharge. Until CMS can confirm the inter-rater reliability of function measures that are used for payment, displaying such measures for individual IRFs could unfairly advantage some providers over others.

Conclusion

MedPAC appreciates your consideration of these issues. The Commission values the ongoing collaboration between CMS and MedPAC staff on IRF policy, and we look forward to continuing this relationship.

If you have any questions regarding our comments, please do not hesitate to contact James E. Mathews, MedPAC's Executive Director, at 202-220-3700.

Sincerely,

Francis J. Crosson, M.D.
Chairman

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